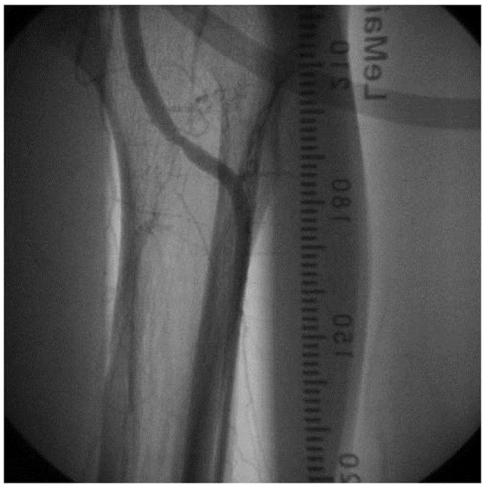
roentogenogram. A computed tomographic (CT) scan of the chest revealed a huge mass (8×13 cm) with lobulated border and necrotic cavities. The tumor extended directly to the left atrium via the left pulmonary vein. A trans-esophageal echocardiography revealed huge mobile mass in the left atrium which protruded into the left ventricle across the mitral valve during diastole. The abdominal aorta was totally occluded down to the common iliac arteries due to possible tumor emboli.
An emergency aortography showed a total occlusion of the abdominal aorta at its bifurcation, which was presumed to be due to tumor emboli from the left atrium.
An emergency embolectomy was performed with hybrid surgical and endovascular intervention using a Fogarty balloon catheter and aspiration catheter through arteriotomy in the bilateral common femoral arteries. Substantial amount of thromboembolic material including tumor-like tissue and thrombus were retrieved, and reperfusion to both lower limbs were successfully accomplished. The histopathologic examination of the retrieved material revealed pleomorphic carcinoma.

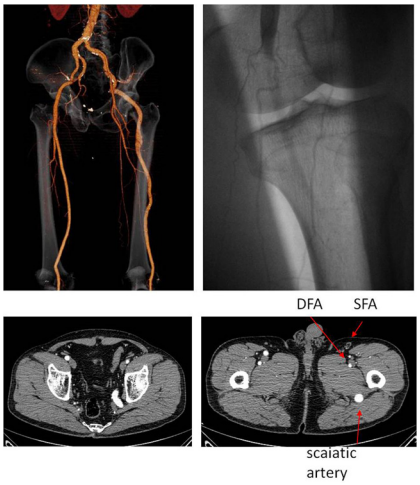


TCTAP C-225

Persistent Sciatic Arterial Aneurysm Documenting as Arteriosclerosis Obliterance Which Was Treated with Stenting and Kissing Balloon Technique

Hiroaki Yamamoto
Nagano Chuo Hospital, Japan

[Clinical Information]
Patient initials or identifier number:
ID:45385
Relevant clinical history and physical exam:
At 60 years-old, the patient suffered from hyperlipidemia and hypertension. Each diseases were well controlled. At 64 years-old when walking along the road, he suddenly suffered from left lower leg pain, and felt cold sensation. One month after, he consulted our hospital because the symptom was not becoming well. His left popliteal artey was weakly felt, and dorsal pedis was not felt at all. His ankle brachial artery index was 0.74. There was no arrhythmia in his pulse.
Relevant test results prior to catheterization:
Electrocardiogram showed almost no abnormality including arrhythmia. CK, AST, and LDH was all within normal range. CT angiography revealed left persistent sciatic artery and slight enlargement of diameter below the hip joint level.
Relevant catheterization findings:
His left superficial femoral artery was fairly hypoplastic, and persistent sciatic artery was observed. There was slight enlargement of artery at the level of hip joint. Just below knee, popliteal artery was occluded. Right femoral artery had normal appearance.
[Interventional Management]
Procedural step:
At first, guidewires (cruise, agosal) were inserted to posterior tibial artery (PTA) and anterior tibial artery (ATA). There was slight difficulty to pass CTO of PTA, and using IVUS the guidewire seemed to pass through pseudolumen. ATA lesion seemed to be thrombotic. So after KBT (Sterling2/20mm, Sterling4/60mm) of both arteries with POBA, the flow of PTA was incomplete. We preferentially recanalized ATA and deferred PTA stenting to be afraid of future stent thrombosis. Complaints of patient improved so much, however still he had intermittent claudication. Three month after, we retried angioplasty. This time, preoperative angiography showed complete occlusion of PTA and proximal sciatic artery had small aneurysm. We implanted stents (Express SD4/19, Genesis4/18mm) to PTA. After KBT of PTA and ATA, angiography revealed good dye opacification.



Case Summary:
Persistent sciatic artery aneurysm is rare disease, the number of which is slightly over 100 cases in English literature. Almost all documented cases were treated with surgical intervention. Reports concerning IVT including stenting were extremely rare. Two step intervention for such thombosis-related lesion is fairly reasonable procedure and brings excellent results.